HHS System Annual Federal Funds Report For State Fiscal Year 2017

As Required by Government Code, Chapter 531. Health and Human Services Commission Subchapter B., Powers and Duties, Section 531.028(c)

Health and Human Services

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Health and Human Services

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Executive Summary

The Texas Health and Human Services Commission is submitting the annual *Federal Funds Report for State Fiscal Year 2017* in accordance with Government Code, Section 531.028(c). This report highlights the critical role of federal funding in the Health and Human Services (HHS) system in Texas.

For fiscal year 2017, four state agencies comprised the HHS system:

- Department of Aging and Disability Services (DADS)
- Department of Family and Protective Services (DFPS)
- Department of State Health Services (DSHS)
- Health and Human Services Commission (HHSC)

For state fiscal year 2017, HHS agencies expended approximately $40.5 billion in All Funds. Federal Funds comprised approximately 56 percent or $22.6 billion of agency funds. (See Figure 1)

HHS System Federal Funds as a Percent of Federal Funds
For State Fiscal Year 2017

Figure 1 ($ in millions)

Agency	Federal Funds***	All Funds	Percent Federal Funds of All Funds
DFPS**	$887,839,071	$1,919,938,004	46%
DSHS*	$943,698,144	$2,254,695,120	42%
HHSC/DADS*	$20,807,446,629	$36,361,853,199	57%
TOTAL	**$22,638,983,844**	**$40,536,486,323**	**56%**

*DSHS and HHSC numbers are derived from FY17 Expenditures as reported in the 2018 Operating Budget. DADS expenditures are reported with HHSC's, consistent with the Operating Budget. On 9/1/17, DADS ceased being a separate agency with HHSC incorporating its financial structure.
**DFPS numbers are derived from FY17 Budgeted as reported in ABEST SB1 Conference 2018/2019.
***Excludes employee benefits, certain payments made as a result of local funding sources (Intergovernmental Transfers), and the value of Supplemental Nutrition Assistance Program (SNAP) benefits.

The HHS system agencies utilized almost 200 different sources of federal funds. Of those sources, the top 30 major federal funding streams accounted for approximately 98 percent of all federal funds to the HHS agencies. Medicaid is the largest federal funding source at over $18 billion, accounting for 80 percent of all federal funding. The next largest is Children's Health Insurance Program (CHIP) at approximately $1.7 billion, accounting for seven percent. A table of the top 30 federal funding sources used by the Texas Health and Human Services system is attached as Appendix A.

This report outlines key federal issues which challenge the health and human services agencies and identifies federal funds management practices undertaken to maximize receipt of federal funds to meet the mission of each health and human services agency. These efforts resulted in the state meeting all federal requirements related to state matching and maintenance of effort for fiscal year 2017. Also included are highlights of the current federal budget outlook, pending program authorizations, and agency specific issues associated with federal appropriations or actions.

The effort to ensure Texas optimizes federal funding consistent with state policy goals to the extent allowable is a basic premise in the financial management of all HHS agencies. With the development of federal cost allocation plans, active analysis of federal legislation, and careful assessment of opportunities to enhance federal funds for the state, HHS agencies are continually monitoring federal funding opportunities to ensure efficient and effective use of those dollars as well as any associated general revenue.

1. Introduction

The Annual Federal Funds Report identifies strategies to maximize the receipt and use of federal funds and to improve federal funds management. This report also outlines key federal issues which challenge the health and human services agencies; highlights the current federal budget outlook; discusses pending program authorizations; and notes agency specific issues associated with federal appropriations or actions.

2. Background

Pursuant to Texas Government Code, Section 531.028, the Health and Human Services Commission (HHSC) is responsible for planning and managing the use of all federal funds, including ensuring that the state meets the federal requirements relating to state matching money and maintenance of effort.

Government Code, Section 531.028, requires HHSC to prepare an annual report which identifies strategies to maximize the receipt and use of federal funds and to improve federal funds management. The commission is required to file the report with the Governor, the Lieutenant Governor, and the Speaker of the House of Representatives, not later than December 15 of each year.

During even-numbered years, this report is included within the Consolidated Budget Request for the Health and Human Services system. During odd-numbered years, this report is submitted as a stand-alone report.

3. Federal Funds: Current Issues

Current issues affecting federal funding, such as fragmented continuing resolutions due to delays in passage of federal appropriation bills, the Budget Control Act of 2011 (sequester), changing interpretation and implementation of federal program policy, and rising caseloads for Medicaid and other entitlement programs can affect the state's ability to receive federal funds to maintain existing services to recipients.

In addition, HHS system agencies are implementing state legislative actions, particularly those related to agency consolidation, and assessing potential implications to federal funding streams to ensure continuity of services, seamless transitions for clients, accountability for reporting requirements, and, compliance with state and federal rules and regulations. In addition, agencies are examining the cost allocation methods associated with the federal share of administrative costs for federally funded health and human services programs to ensure the state is maximizing the use of federal funds.

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Federal Budget Outlook

1. Federal Appropriations Bills

On September 28, 2016, a continuing resolution passed to keep the federal government operating through December 9, 2016. The measure imposed a 0.496 percent across-the-board funding reduction to applicable programs to comply with spending caps and included $1.1 billion in fiscal year (FY) 2016 to address the Zika virus. On December 9, 2016, Congress passed an additional continuing resolution, set to expire April 28, 2017. On April 28, an additional short-term continuing resolution was passed, while Congress finalized the omnibus appropriations bill. The Consolidated Appropriations Act, 2017 was passed on May 4, 2017. The Consolidated Appropriations Act, 2017 included level funding for many programs. Mandatory programs saw an estimated three percent increase, largely driven by growth in Medicaid. A few mandatory programs, such as the Title XX Social Services Block Grant, are subject to FY 2017 sequestration of non-exempt mandatory programs. On September 8, 2017, the House and Senate approved a continuing resolution for FY 2018 that will keep the federal government operating through December 8, 2017. A further extension is pending.

2. Future Sequestration Impact

The Budget Control Act of 2011 requires funding reductions to achieve savings and to limit the size of the federal budget. This is commonly referred to as sequestration. Reductions under the act were extended an additional two years by the Bipartisan Budget Act of 2013 requiring cuts over federal fiscal years 2013-2023. If Congress enacts appropriations that exceed the caps set in legislation, a sequestration is automatically triggered to reduce appropriations to within the required limits.

Both discretionary and mandatory federal programs are subject to sequestration; however, some programs are exempt, including Medicaid, CHIP, and Temporary Assistance for Needy Families (TANF). Factors, such as level of growth in mandatory programs, and rule exceptions for certain programs, such as a limit on reductions to

Medicare, may impact the calculations for the reductions. Additionally, Congress could enact legislation at any time that repeals the law or modifies the exemptions or rules associated with sequestration.

If future decreases in federal funding occur to discretionary and mandatory programs covered under sequestration, reductions in numbers of clients served and levels of services provided by the Texas HHS system could occur. Estimates of future year reductions are not possible as the exact reduction depends on the factors applied and the base determined as subject to sequestration after applying defined exemptions and special rules.

The HHS system agencies continue to monitor and analyze available information and assess the potential impact of a future federal sequestration to clients and services. Federal agencies have not provided specific guidance about future sequestration reductions.

Pending Federal Reauthorizations

Many of the health and human services system federal grant programs are pending program reauthorizations, some for many years. Historically, federal grant programs are extended through the federal appropriations bills passed by Congress for each federal fiscal year.

The following summarizes the status of key programs as of December 8, 2017:

Funding for CHIP expired September 30, 2017. On October 4, 2017, the Senate Finance Committee approved the Keep Kids' Insurance Dependable and Secure Act (KIDS Act, S. 1827). The House Energy and Commerce Committee also approved its bill, the Helping Ensure Access for Little Ones, Toddlers, and Hopeful Youth by Keeping Insurance Delivery Stable Act (HEALTHY KIDS Act, H.R. 3921). Both bills would extend funding for CHIP and related programs through FY 2022, and maintain the Affordable Care Act's (ACA) 23 percentage point increase in the enhanced federal matching rate through FY 2019. The House bill incorporates provisions not in the Senate bill, including offsets, eliminating the Medicaid Disproportionate Share Hospital (DSH) cuts for FY 2018 while extending the cuts for two later years. (Additional discussion regarding DSH occurs on page 17 of this report). The House passed its bill to reauthorize CHIP, but movement in the Senate has stalled due to bipartisan negotiations around offsets.

The Affordable Care Act provided an increase in the Enhanced Federal Medical Assistance Percentage (EFMAP) for CHIP by 23 percentage points (certain expenditures were excluded) beginning in federal fiscal year 2016 and continuing

through fiscal year 2019. The Medicare Access and CHIP Reauthorization Act of 2015 maintained this increase for EFMAP and reduced the allotments available to states in federal fiscal year 2018 by one-third.

The "child nutrition programs," including the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), are primarily authorized by permanent statutes, the Richard B. Russell National School Lunch Act and the Child Nutrition Act of 1966. These statutes and programs were last reauthorized by the Healthy, Hunger-Free Kids Act of 2010. Some of the authorities created or extended in the last reauthorization law expired September 30, 2015. The Consolidated Appropriations Act, 2017 provided funding for FY 2017.

The TANF program was created in 1996 (P.L. 104-193) and replaced the Aid to Families with Dependent Children (AFDC). TANF is administered by the U.S. Department of Health and Human Services and is an entitlement to the states.

TANF has four program goals:

- To provide assistance to needy families so that children can be cared for in their own homes or in the homes of relatives;
- End the dependence of needy parents on government benefits by promoting job preparation, work and marriage;
- Prevent and reduce the incidence of out of wedlock pregnancies and establish annual numerical goals for preventing and reducing the incidence of these pregnancies; and
- Encourage the formation and maintenance of two-parent families.

Since program authorization expired in 2010, Congress has continued TANF with short-term extensions rather than a full reauthorization. The most recent extension was part of the Consolidated Appropriations Act, 2017 which extended TANF and the TANF Contingency Fund through federal fiscal year 2018 at current funding levels.

The Ryan White Human Immunodeficiency Virus (HIV)/ Acquired Immune Deficiency Syndrome (AIDS) Treatment Extension Act of 2009 (P.L. 111-87) authorized the program which is the largest federal program specifically dedicated to providing HIV care and treatment. The legislation was first enacted in 1990. The program has been extended through the federal appropriations process since expiring in 2013. Despite no reauthorization from Congress, appropriations can continue because the act is not a self-repealing appropriation. The program has been adjusted with each reauthorization to accommodate new

and emerging needs, such as increased emphasis on core medical services and changes in funding formulas. DSHS continues to monitor appropriations and assess the implementation of the Affordable Care Act to determine potential fiscal impact to the state.

Agency Specific Federal Issues

This section includes information on federal funding issues affecting specific Texas HHS agencies.

1. Title IV Part E Foster Care Assistance (DFPS)

Texas continues to experience a decline in federal financial participation for the federal Title IV-E Foster Care program which helps to provide safe and stable out-of-home care for children. The methodology for claiming funds uses a population ratio which is the percentage of each state's foster care caseload that qualifies for federal financial participation. The percentage allocated to Title IV-E Foster Care Assistance Administration is computed by dividing the total number of children determined eligible for Title IV-E Foster Care Assistance and residing in a Title IV-E eligible (licensed) foster care placement/living arrangement by the total number of children who are placed away from their parents or guardians and reside in 24-hour substitute care in placements in a foster care setting.

The ratio is used to determine the amount of federal Title IV-E Foster Care administrative claiming available for child protective services direct delivery staff. The average annual rate for fiscal year 2017 was 31.6 percent as compared with fiscal year 2016 at 32.2 percent.

There are two major factors contributing to this decline. Income eligibility for Title IV-E is linked to standards from the 1996 Aid to Families with Dependent Children (AFDC). These standards can only be adjusted through a federal law change. To qualify for IV-E funds today, the minimum household income eligibility level is lower than in 1996. Additionally, relative or kinship placements are not Title IV-E eligible placements since they have not been verified as a foster home. As the percentage of children in conservatorship who are in relative or kinship placements increases, the population ratio decreases.

2. Disability Determination Services Program

The Disability Determination Services (DDS) program is 100 percent federally funded by the Social Security Administration (SSA) and is exempt from the sequestration legislation.

The DDS program has operated under a federal hiring freeze the last few years. Staffing levels have been down since 2011 and currently DDS has 243 vacant positions. While the program continues to perform better than the national average, DDS continues to work with the SSA to discuss alternatives for workload capacity and staffing strategies.

3. Early Childhood Intervention (HHSC)

Early Childhood Intervention (ECI) is a statewide program for families with children, birth to three years old, with disabilities and developmental delays. Based on available appropriations, HHSC funds a portion of the total ECI program budget through a variety of state and federal funding sources including:

- General Revenue
- Foundation School Funds
- Individual with Disabilities Education Act (IDEA) Part B
- IDEA Part C
- Temporary Assistance for Needy Families (TANF)
- Medicaid

The Program for Infants and Toddlers with Disabilities (PART C of the Individuals with Disabilities Education Act (IDEA)) is the largest funding source for the ECI program. The federal agency administering IDEA Part C funding is the Office of Special Education Programs (OSEP), which is part of the Department of Education. The federal requirements for Early Childhood Intervention (ECI) are similar to regulations for public education and require states to provide all eligible children with early intervention services as defined by 34 C.F.R. §303.13, although states determine the eligibility requirements. Despite federal regulations requiring the ECI program to largely function as an entitlement program where any child who is screened eligible is served, IDEA Part C funding for the program is capped. 34 C.F.R §303.732 requires that for each fiscal year, the Department of Education will allot IDEA Part C funds to each state an amount that bears the same ratio to the aggregate amount as the number of infants and toddlers in the state bears to the number of infants and toddlers in all states. Federal funding has remained fairly level for multiple years, despite increased population and caseload growth in Texas.

4. Public Health Preparedness (DSHS)

The 2013 reauthorization of the 2006 Pandemic All-Hazards Preparedness Act provided states and independently funded jurisdictions with funding for public health and medical preparedness programs, such as the Hospital Preparedness Program (HPP) and the Public Health Emergency Preparedness (PHEP) Cooperative Agreement grants.

Additionally, the act provided increased flexibility in allowing states to temporarily deploy federally funded state personnel, funded in programs other than preparedness, to meet critical community needs in a disaster. Texas uses dollars from these federally funded programs to fund public health and medical preparedness activities at the local, regional and state level.

In FY 2017, Texas received mostly level funding to sustain public health and healthcare systems preparedness activities.

In FY 2015, Texas received one-time supplemental HPP Ebola preparedness funding. These funds supported hospital preparedness activities including establishing regional treatment centers, assessment hospitals, and health care coalitions to ensure overall health care system preparedness for Texas; development of a national network for Ebola patient care, including establishing University of Texas Medical Branch as one of approximately ten federally designated regional Ebola and other special pathogen treatment centers; and, the purchase of regional stockpiles of personal protective equipment.

In FY 2015, Texas also received one-time supplemental PHEP Ebola preparedness funding. These funds supported eight regional highly contagious infectious disease (HCID) workshops concentrating on Ebola virus disease (EVD); upgraded Texas' laboratory response network (LRN) capacity to test for EVD; supported PHEP participating local health departments to prepare for and respond to EVD; and, the purchase of personal protective equipment for state and regional caches.

Public health and healthcare system preparedness funds remained fairly level in FY 2016, with the exception of PHEP related funding, which was reduced by approximately $3.6 million. Funding allocations reduced at the state level were shifted by the CDC to Zika response in Puerto Rico. Texas was able to mitigate the funding reduction by using carryover funds to continue the PHEP activities associated with the reduced funding, including the funding of local health department PHEP activities. The $3.6 million was restored to Texas by CDC later that year. In addition, Texas also received one-time supplemental funding from the CDC for Zika Public Health Preparedness and Response (PHPR). These funds were awarded based on the risk of local transmission and could be used to rapidly identify and investigate possible outbreaks of Zika virus, coordinate a comprehensive response to Zika prevention and outbreaks, identify and connect families affected by Zika to community services, and to purchase preparedness resources like mosquito repellant, and supplies for Zika prevention kits. Texas received approximately $6 million in Zika PHPR funds that are available through June 2018.

Moving forward, CDC established the Public Health Crisis Response (PHCR) funding program. This program will establish an Approved-But-Unfunded (ABU) list of grantees to enhance the state's ability to rapidly mobilize and respond to public health emergencies identified by CDC. Texas is in the process of submitting an initial $5 million preapproval application. Once Texas is approved, CDC expects monetary resources can be distributed to the state within 10–14 days of an emergency as opposed to two-three months in the regular supplemental funding process.

DSHS continues to monitor activities at the federal level in order to assess potential future impacts to public health preparedness funding to Texas. If future federal allocations are reduced to Texas it may diminish state, regional and local public health and healthcare partners' capacity in an all-hazards response. Such capacity may include, but is not limited to; epidemiologic surveillance; investigation and response to disease outbreaks and environmental health concerns; provision of medical surge of essential healthcare providers and services; and, planning, training and exercising efforts for mitigating the health impact of natural and man-made disasters.

5. Title V Maternal and Child Health Services Block Grant (DSHS/HHSC)

The federal Maternal and Child Health Block Grant is authorized under Title V of the Social Security Act and is the longest-standing public health legislation in American history. The original authorization occurred in 1935. The Title V block grant funds essential maternal and child health services while maintaining state flexibility in determining priority needs to improve the health and well-being of women and children. Recently, the Maternal Child Health Bureau of the Health Resources and Services Administration led a 21-month visioning process to help inform the development of grant guidance. As a result, the block grant underwent a transformation to focus on reducing reporting burden, maintaining flexibility, and increasing accountability to improve the ability of States to tell a more coherent and compelling narrative about the impact of Title V funding in their State.

The federal Health Resources and Services Administration (HRSA) determines the allocation formula for the Title V Maternal and Child Health Services Block Grant using the American Community Survey poverty estimates. The formula is based on the number of children living in poverty (in an individual state) as compared to the total number of children living in poverty in the United States. As a Title V Block Grant recipient, the State of Texas is required to spend at least 30 percent of funds on children and adolescents, at least 30 percent of funds on children with special health care needs, and no more than 10 percent on administrative costs. Texas is also required to submit an annual application and report to HRSA, submit a statewide needs assessment every five years, and report ongoing needs assessment findings in

each annual Block Grant application. The last 5-year needs assessment was submitted in July 2015.

As part of the recent Block Grant transformation, guidance was issued to states to streamline reporting and reduce the number of performance measures. Data from the 2015 needs assessment informed the selection of state-identified priority needs, eight new National Performance Measures, and four new State Performance Measures through which to track progress in improving maternal and child health in Texas. Through the implementation of data-driven, evidence-based/informed initiatives, Texas remains committed to the Title V vision of improving the health and well-being of the nation's mothers, infants, children and youth, including children and youth with special care needs (CYSHCN) and their families.

6. Affordable Care Act Funding to the HHS System (HHSC/DSHS/DADS)

In 2010, the Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Affordability Reconciliation Act of 2010, collectively known as the Affordable Care Act (ACA), were signed into federal law.

The ACA established the Prevention and Public Health Fund (PPHF) to provide expanded and sustained national investments in prevention and public health, to improve health outcomes, and to enhance health care quality. Beginning in 2010, the PPHF began funding public health efforts such as building public health infrastructure for immunizations, tobacco prevention, and public health workforce and training. Since 2010, funding for certain core public health activities has shifted from CDC appropriated funds to funds made available through the ACA PPHF. Texas has received funding for several core public health activities through the PPHF including breast and cervical cancer screenings, suicide prevention, the Preventive Health and Health Services Block Grant, abstinence education programs, and several chronic disease prevention activities.

Beginning in calendar year 2014, ACA required covered entities under Section 9010 to pay the ACA health insurance provider (HIP) fee. The fee is an excise tax, and therefore is non-deductible for federal tax purposes. Covered entities were assessed the calendar year 2016 ACA HIP fee based on premiums paid to the affected Managed Care Organizations (MCOs) and Dental Maintenance Organizations (DMOs), or "insurers," in calendar year 2015. The 2016 payment by the insurers was made to the Internal Revenue Service (IRS) by September 30, 2016. HHSC reimbursed insurers for this payment in March 2017. The total state fiscal year 2017 ACA HIP fee payment to all MCOs/DMOs (including HHSC and DSHS programs) was approximately $275 million, of which $113.1 million was state general revenue.

The payments to the affected MCOs/DMOs included three parts:

- The amount of the health insurance provider fee attributable to Texas Medicaid and CHIP premiums;
- The federal income tax liability, if any, that the insurer incurs as a result of receiving HHSC's payment for the amount of the ACA HIP Fee; and
- Texas state premium tax attributable to the capitation adjustment.

Certain insurers are exempt from the ACA HIP Fee. Notably, insurers that are non-profit, owned by public entities, or have greater than 80 percent of gross revenues from government supported programs that target low-income, elderly, or disabled populations. The federal Consolidated Appropriations Act, 2016, included a one-year moratorium in calendar year 2017 on the ACA health insurance provider's fee. The moratorium pertains to calendar year 2016 premium revenue, which in Texas Medicaid/CHIP would have been paid in state fiscal year 2018 if the current process for reimbursing MCOs continues. The Texas Attorney General is in litigation over the legality of assessing this fee on Medicaid and CHIP programs.

Beginning in June 2015 under ACA, certain public and mental health activities were covered by private health insurance plans. These activities included: infectious disease control, prevention, and treatment; health promotion and chronic disease prevention; laboratory services; primary care and nutrition services; behavioral health services; community capacity; and state-owned and privately-owned hospital services.

The health and human services system agencies continued implementing certain ACA-related programs and initiatives during FY 2017, such as: the Community First Choice and Presumptive Eligibility. The status of these programs or initiatives is addressed below**.**

Community First Choice - CFC (HHSC)

The Community First Choice (CFC) federal program allows states to receive a six percent increase in federal matching funds to provide home and community-based attendant services and supports as a state plan benefit for individuals with disabilities who are enrolled in Medicaid and require an institutional level of care.

Beginning in FY 2015, Texas provided the following CFC services:

- Personal Assistance Services
- Habilitation Services
- Emergency Response Services
- Support Consultation Services

The six percent increase in federal matching funds would also be received for services that are currently provided to individuals meeting intermediate care facility level of care criteria for individuals with an intellectual disability or related condition through four intellectual and developmental disability waivers administered by DADS. The CFC services are provided as a state plan service rather than as a waiver benefit.

Disproportionate Share Hospital (DSH) Program Reductions (HHSC)

States make Medicaid Disproportionate Share Hospital (DSH) payments to hospitals serving a disproportionate share of low income patients and experiencing high levels of uncompensated care costs. While DSH payments predate the Affordable Care Act, the ACA included reductions to state DSH allotments.

Subsequent legislation has delayed implementation dates, most recently the Bipartisan Budget Act and the Medicare Access and CHIP Reauthorization Act of 2015 shifted the reductions to fiscal years 2018 through 2025. The Affordable Care Act provisions related to expanded coverage through private insurance and Medicaid were intended to reduce the amount of uncompensated care covered by hospitals and providers, however, certain Medicaid expansions mandated by the ACA were determined by subsequent court actions to be optional to states.

On November 3, 2017, in the *Federal Register*, the federal government released disproportionate share hospital preliminary allotments for federal fiscal year 2017. The allotment for Texas was $1,049.6 million federal funds, as compared to the federal fiscal year 2016 preliminary allotment of $1,039.2 million federal funds. The non-federal share is determined by the annual FMAP percentage.

Presumptive Eligibility (HHSC)

Presumptive Eligibility was implemented in Texas in February 2015. The ACA mandated that states allow qualified hospitals the option to determine Medicaid presumptive eligibility for pregnant women, children, low-income caretaker relatives, and foster care groups. States are prohibited from requiring qualified hospitals to verify eligibility criteria and only have the option to require the hospital to ask the applicant to attest to the applicants U.S. citizenship/alien status and residency. Qualified hospitals must make the eligibility determination based on information provided by the applicant. A qualified hospital must meet the following requirements to participate in the Texas Presumptive Eligibility program:

- Participates as a provider under the State's Medicaid plan or 1115 waiver;
- Informs HHSC of intention to make presumptive eligibility determinations;

- Agrees to make presumptive eligibility determinations consistent with the State's policies and procedures;
- Assists individuals in completing and submitting the full application for Medicaid assistance and understanding the documents needed to determine Medicaid ongoing; and
- Has not been disqualified by the State.

Provider Enrollment Fee (HHSC)

In FY 2015, HHSC delegated authority to DADS to collect this fee for Long Term Services and Supports providers. The provider screening and enrollment fees are defined as payments from medical providers and suppliers required by the federal Centers for Medicare and Medicaid Services (CMS) as a condition for enrolling as a provider in the Medicaid and CHIP programs. The state collects and receives the funds as Appropriated Receipts - Match for Medicaid. Collected funds may be expended as authorized by federal law to support provider enrollment. In the event revenues collected are greater than expenditures, any unused fee balances shall be disbursed to the federal government as required by federal law.

7. Healthcare Transformation and Quality Improvement Program 1115 Waiver (HHSC)

Texas received approval for the Section 1115 Transformation Waiver in December 2011. The five-year demonstration waiver allowed Texas to expand its use of Medicaid managed care to achieve program savings while preserving locally funded supplemental payments to safety net hospitals. In May 2017, the federal government extended the waiver through December 2017. A five-year renewal is currently being negotiated between HHSC and the Centers for Medicare and Medicaid Services. The waiver includes an Uncompensated Care (UC) pool and a Delivery System Reform Incentive Program (DSRIP) pool. The UC pool provides payments to hospitals and other providers for a portion of their uncompensated care. DSRIP payments are made to hospitals and other providers based on the implementation of initiatives which improve health care quality for Medicaid and low-income populations. The non-federal share for the waiver supplemental payments is primarily provided by local governmental entities.

8. Social Services Block Grant (HHSC/DFPS/DSHS/Texas Workforce Commission (TWC)

Title XX Social Services Block Grant (SSBG) funds are appropriated by the Texas Legislature to Texas state agencies to help meet specified social service needs for defined low income and at-risk populations.

Title XX was made a block grant by the Omnibus Budget Reconciliation Act of 1981, PL 97-35. Under this block grant, the state may provide social services directed at the goals of Title XX and may make expenditures for administration and training. The goals for the individuals served include:

- Achieving or maintaining self-sufficiency - economic, physical, and otherwise to include preventing, eliminating, or reducing dependency;
- Preventing or remedying neglect, abuse, and exploitation of children and adults, and preserving, rehabilitating, or reuniting families;
- Preventing or reducing inappropriate institutional care by providing for community-based care, home-based care, or other forms of less intensive care; and
- Securing referral or admission for institutional care when other forms of care are not appropriate or providing services to individuals in institutions.

Achievement of these goals is sought through several programs administered by HHSC, DSHS, DFPS, and the Texas Workforce Commission (TWC).

As in previous years, the FY 2017 budget includes language that allows for 10 percent of TANF funding to be transferred to SSBG. Due to mandatory sequestration, SSBG was funded at $1.7 billion, but this funding was reduced to $1.6 billion. Despite sequestration, Texas received a slight increase from $133.2 million in FY 2016 to $134.5 million in FY 2017 due to demographic factors.

9. Money Follows the Person (HHSC)

In 2007, HHSC and DADS successfully competed for a Deficit Reduction Act of 2005 Money Follows the Person (MFP) Demonstration grant award to build upon and enhance its existing Promoting Independence/Money Follows the Person initiatives. The MFP Demonstration provides financial incentives to move individuals from institutions to community settings and includes an enhanced FMAP for client services costs. The MFP Demonstration helps people who are residing in a nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID). It provides individuals long-term services in the community setting of

their choice without having to be placed on an interest list. The MFP Demonstration also supports direct services, such as behavioral health and relocation assistance, as well as projects designed to enhance the infrastructure of community based services. Examples of projects include customized employment services and enhanced services and service coordination for individuals with intellectual and developmental disability with complex medical/behavioral health needs.

Congressional authorization for the MFP Demonstration ended September 30, 2016. The Centers for Medicare and Medicaid Services (CMS) awarded a supplemental grant for states to implement sustainability strategies. Supplemental funds allocated by Congress were less than expected. As a result, the state will close-out activities one year earlier than expected. Transitions from institutional services to home and community-based services will continue as before the state received the MFP Demonstration grant. The state will no longer collect the enhanced match for individuals who transition after December 31, 2017. The MFP Demonstration funded projects will conclude no later than the end of state fiscal year 2019.

10. Hurricane Harvey

On Friday, August 25, 2017, Hurricane Harvey made landfall as a Category 4 hurricane striking the southeast coast of Texas. Governor Abbott declared a state of disaster in 30 Texas counties. On August 25, the President declared that a major disaster exists in the state of Texas. Subsequently, the Administration requested an appropriation of $7.85 billion in federal resources for the response and initial recovery efforts related to Hurricane Harvey. HHSC and DSHS, in conjunction with the Texas Department of Public Safety Texas Division of Emergency Management, applied for federal funding from Federal Emergency Management Agency (FEMA). HHSC has also requested funding from other federal agencies. Below in Figure 2 are federal funding amounts received or requested as of this report:

Hurricane Harvey Federal Funding Requested/Received by HHS Agencies

Figure 2 ($ in millions)

Agency	Federal Funding	Amount*
HHSC	Medicaid	$40,657,501
HHSC	FEMA Disaster Case Management	$50,100,000
HHSC	Crisis Counseling - Immediate Services Program	$2,831,322
HHSC	Crisis Counseling - Regular Services Program	$12,045,063
HHSC	Other Needs Assistance (ONA) Client Services	$300,000,000
HHSC	Other Needs Assistance (ONA) Administrative	$14,400,000
HHSC	Food Benefits at 100 percent	$786,393,941
HHSC	FEMA Disaster Public Assistance	$10,651,772
DSHS	FEMA Disaster Public Assistance	$29,256,947
Total HHS		**$1,246,336,546**

*DFPS reported minimal Harvey costs related to travel which were absorbed by the agency.

HHS will continue to request additional federal funding, as it becomes available, to assist with Hurricane Harvey recovery efforts.

Federal Funds Enhancement Initiatives

The Texas HHS agencies were successful in efforts to enhance revenue and maximize the use of Federal Funds to provide services during the last fiscal year. By working with various federal agencies, the state identified expenditures where additional federal funds could be accessed and qualified for new opportunities to bring additional dollars to Texas. Agencies continue to seek available funding and identify innovative ways for increasing access to federal funds to support the state's mission and interests related to health and human services.

1. Minimum Payments Amounts Program (HHSC)

Effective March 1, 2015, upon carve-in of nursing facilities (NF) to managed care, HHSC created a new minimum payment to eligible NFs to be made through the managed care organizations. This program, referred to as the Minimum Payment Amounts Program (MPAP), was developed in an effort to continue a certain level of funding to NFs that had previously participated in the NF upper payment limits (UPL) program, a program which is prohibited by federal regulations in a managed care environment. MPAP provided increased funding to 287 NFs to improve the quality of the care they provide to Medicaid NF residents. The non-federal share for this program was provided by intergovernmental transfers from the non-state governmental entities that own the NFs. MPAP payments lag and provided

approximately $440.9 million in additional federal funds to participating NFs through FY 2017. CMS has discontinued the program effective August 31, 2016.

2. Quality Incentive Payment Program (HHSC)

Effective September 1, 2017, the purpose of the Quality Incentive Payment Program (QIPP) is to transition from MPAP to one which improves quality and encourages innovation in the provision of nursing facility (NF) services. Payments are made by Managed Care Organizations to contracted nursing facilities based on their performance related to agreed-upon goals involving the treatment of their residents, including, use of restraints, falls, pressure ulcers, and antipsychotic drug use. QIPP provides payments to 514 nursing facilities. The non-federal share of the program is provided by non-state governmental entities that own NFs. QIPP is expected to provide about $400 million All Funds to participating NFs for FY 2018.

3. Network Access Improvement Program (HHSC)

Effective March 1, 2015, several health plans implemented programs aimed at improving network access for Medicaid members. The Network Access Improvement Program (NAIP) is designed to further the state's goal of increasing the availability and effectiveness of primary care for Medicaid beneficiaries by incentivizing various institutions to provide high quality, well-coordinated, and continuous care. NAIP was expected to provide approximately $427.7 million All Funds in state fiscal year 2017, of which $240.3 million was federal funding.

4. TANF Contingency Fund (HHSC)

TANF Contingency fund provides states with additional federal funds to assist in meeting the needs of low income families during periods of economic downturn. States access TANF Contingency funds when they reach high levels of unemployment and/or exceed target levels of SNAP caseloads. Contingency funds may be used only in the fiscal year for which they are awarded and may not be carried over for use in a succeeding fiscal year. These funds can be used for any purpose for which regular TANF funds are used.

To draw upon Contingency funds, a state must both (1) meet a test of "economic need" and (2) spend from its own funds more than what the state spent in fiscal year 1994 on cash, emergency assistance, and job training in TANF's predecessor programs. A state meets the "economic need" test if its seasonally adjusted unemployment rate averaged over the most recent three-month period is at least 6.5 percent and at least 10 percent higher than its rate in the corresponding three-month period in either of the previous two years; or its SNAP caseload over the most recent three-month period is at least 10 percent higher than the adjusted

caseload in the corresponding three-month period in fiscal year 1994 or fiscal year 1995.

In 2017 Texas applied for and received approximately $51.4 million in additional funds requested through the TANF Contingency Funds grant. A 2018 application has recently been submitted.

Unlike the regular TANF block grant which provides a fixed funding amount to states regardless of economic conditions, the TANF Contingency Fund provides additional TANF funds to states when states reach high levels of unemployment and/or exceed expected SNAP caseloads. Texas met the threshold, based on SNAP caseload. If the state remains eligible and if Congress continues appropriations, HHSC will continue to apply for TANF Contingency Funds.

5. Uniform Hospital Rate Increase Program (HHSC)

The Uniform Hospital Rate Increase Program (UHRIP) is designed to reduce hospital uncompensated care costs through enhanced payments to hospitals for medically necessary covered services provided to Medicaid managed care members. Federal rules permit states to raise reimbursement rates for specific providers by dollar amounts or percentages and to direct Managed Care Organizations to make those enhanced payments to providers through increased capitation amounts. The non-federal share of UHRIP program funding is provided by non-state governmental entities. Effective December 1, 2017, the program became operational in the Bexar and El Paso managed care Service Delivery Areas. Operations are scheduled in all remaining Service Delivery Areas, but Travis, in March 2018. Hospitals in the Travis Service Delivery Area chose not to participate. The estimated FY 2018 All Funds amount for UHRIP is $600 million.

Conclusion

For state fiscal year 2017, the HHS system agencies utilized almost 200 different sources of federal funds totaling $22.1 billion of agency funds, while meeting federal requirements for state matching money and maintenance of effort.

Current issues affecting federal funding, such as fragmented continuing resolutions, the Budget Control Act of 2011 (sequester), changing interpretation and implementation of federal program policy, and rising caseloads for Medicaid and other entitlement programs are all issues which affect the state's ability to receive federal funds to maintain existing services to recipients.

To ensure the HHS system optimizes federal funding consistent with state policy goals, HHS agencies develop federal cost allocation plans, pursue active analysis of federal legislation, and carefully assess opportunities to enhance federal funds for the state. HHS agencies continue to monitor federal funding opportunities to identify strategies to maximize the receipt and use of federal funds and to improve federal funds management.

List of Acronyms

Acronym	Full Name
ABEST	Automated Budget and Evaluation System of Texas
ABU	Approved but Unfunded
ACA	Affordable Care Act
AFDC	Aid to Families with Dependent Children
AIDS	Acquired Immune Deficiency Syndrome
CDC	Centers for Disease Control and Prevention
CFC	Community First Choice
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
DADS	Department of Aging and Disability Services
DDS	Disability Determination Services
DFPS	Department of Family and Protective Services
DMO	Dental Maintenance Organization
DSH	Disproportionate Share Hospital Program
DSHS	Department of State Health Services

Acronym	Full Name
ECI	Early Childhood Intervention
EFMAP	Enhanced Federal Medical Assistance Percentage
EVD	Ebola Virus Disease
FEMA	Federal Emergency Management Agency
FMAP	Federal Medical Assistance Percentage
FY	Fiscal Year
HCID	Highly Contagious Infectious Disease
HHS	Health and Human Services
HHSC	Health and Human Services Commission
HIP	Health Insurance Provider
HIV	Human Immunodeficiency Virus
HPP	Hospital Preparedness Program
HRSA	Health Resources and Services Administration
ICF/IDD	Intermediate Care Facilities for Individuals with Intellectual Disabilities
IDEA	Individuals with Disabilities Education Act
IRS	Internal Revenue Service

Acronym	Full Name
LBB	Legislative Budget Board
LRN	Laboratory Response Network
MCO	Managed Care Organization
MFP	Money Follows the Person
MPAP	Minimum Payment Amounts Program
NAIP	Network Access Improvement Program
NF	Nursing Facility
ONA	Other Needs Assistance
PHCR	Public Health Crisis Response
PHEP	Public Health Emergency Preparedness
PPHF	Prevention and Public Health Fund
QIPP	Quality Incentive Payment Program
SHARS	School Health and Related Services
SNAP	Supplemental Nutrition Assistance Program
SSA	Social Security Administration
SSBG	Social Services Block Grant

Acronym	Full Name
TANF	Temporary Assistance for Needy Families
TWC	Texas Workforce Commission
UHRIP	Uniform Hospital Rate Increase Program
UPL	Upper Payment Limits
WIC	Women, Infants, and Children

Appendix A.

Appendix A - FY 2017 Top 30 Federal Funding Sources ($s in millions)*			
Number	**CFDA**	**Method of Finance**	**FY 2017**
1	93.778.000	XIX Medical Assistance Program	$16,591,375,299
2	93.767.000	State Children's Insurance Program (CHIP)	$957,584,740
3	93.767.778	CHIP for Medicaid (EFMAP)	$762,405,239
4	10.557.001	Special Supplemental Nutrition Program (WIC)	$558,668,058
5	93.778.004	XIX Medical Assistance Program Administration at 75 percent	$478,211,552
6	93.778.007	XIX Medical Assistance Program Administration at 100 percent	$477,300,271
7	93.558.000	Temporary Assistance for Needy Families	$402,528,577
8	93.778.003	XIX Medical Assistance Program 50 percent	$266,977,499
9	93.778.009	XIX Medical Assistance Program - School Health and Related Services (SHARS)	$179,300,272
10	10.561.000	State Admin Matching Grants for Supplemental Nutrition Assist Prog	$175,099,021
11	93.778.005	XIX Medical Assistance Program at 90 percent	$147,306,039
12	93.959.000	Block Grants for Prevention and Treatment of Substance Abuse	$146,465,832
13	96.001.000	Social Security Disability Insurance	$122,477,832
14	93.667.000	Social Services Block Grant	$121,209,665
15	93.659.060	Adoption Assistance Title IV-E at Federal Medical Assistance Percentage	$118,434,594
16	93.917.000	HIV Care Formula Grants	$111,026,694
17	93.658.060	Foster Care Title IV-E at Federal Medical Assistance Percentage	$92,190,531
18	93.658.050	Foster Care Title IV-E Administration at 50 percent	$81,064,223
19	93.958.000	Block Grants for Community Mental Health	$52,362,047
20	84.181.000	Special Education Grants for Infants & Families w/Disabilities	$49,262,543
21	93.778.014	XIX Medical Assistance Program - Stimulus	$43,037,313
22	93.566.000	Refugee and Entrant Assistance - State	$39,512,024
23	93.994.000	Maternal and Child Health Services Block Grants to the States	$37,403,776
24	93.045.000	Special Programs for the Aging - Title III	$36,740,762
25	93.074.002	Public Health Emergency Preparedness	$36,718,306
26	93.558.667	Temporary Assistance for Needy Families to Title XX	$31,564,428
27	93.575.000	Child Care and Development Block Grant	$31,158,166
28	93.556.001	Promoting Safe and Stable Families	$29,769,098
29	93.645.000	Child Welfare Services State Grants	$27,538,333
30	93.777.000	Survey & Certification: Health Care Providers & Suppliers Title XVI	$24,312,520
HHS Total Top 30 Federal Funds			**$22,229,005,254**

*Source: 4.B.Federal Funds Supporting Schedule, Operating Budgets 2018 for DADS, DSHS, HHSC.
DFPS numbers derived from FY17 Budgeted from ABEST SB1 Conference 2018/2019.